UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, STATE OF ILLINOIS, STATE OF MARYLAND, STATE OF WASHINGTON,	:	No. 07-CV-8621 (PAC) (RLE)
Plaintiffs,	:	ECF Case
v.	:	
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,	:	
Defendant.	:	

AMICI CURIAE BRIEF OF THE STATES OF CALIFORNIA, CONNECTICUT, MASSACHUSETTS AND NEW MEXICO IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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The States of California, Connecticut, Massachusetts and New Mexico file this brief amici curiae in support of the plaintiff States of New York, Illinois, Maryland and Washington's (plaintiff States) opposition to the defendant U.S. Department of Health and Human Services' (HHS) motion to dismiss and in support of plaintiff States' motion for summary judgment. The amici states, as administrators of their State Children's Health Insurance Programs (SCHIP), wish to advise the Court of the significant harm that will result from implementation of the August 17, 2007 letter issued by HHS concerning administration of state children's health insurance programs. HHS' letter violates the Administrative Procedure Act and creates onerous, ultra vires restrictions on state SCHIP programs that effectively undermine the states' ability to provide health coverage to thousands of low-income children.

STATEMENT OF INTEREST OF THE AMICI

For the past ten years, the States of California, Connecticut, Massachusetts and New Mexico have provided health insurance to thousands of needy children through their SCHIP programs. Throughout this period, HHS has consistently approved the manner in which the amici states have administered their programs, and the states have consistently complied with the agency's requests. At present, Connecticut and Massachusetts provide health insurance to children in their states who live in families with incomes up to 300 percent of the federal poverty level (FPL), California generally covers children in families with incomes up to 250 percent of the FPL (although extends coverage to certain children with family incomes up to 300 percent of the FPL) and New Mexico covers children in families with incomes up to 235 percent of the FPL.

On August 17, 2007, with no advance warning or opportunity for comment, HHS' Centers for Medicare & Medicaid Services (CMS) issued a letter to state health officials that fundamentally altered the rules governing the SCHIP program. While the new policy purported simply to "clarify" the rules governing coverage of children who live "in families with effective family income levels above 250 percent of the Federal poverty level," the letter's practical effect is to raise insurmountable obstacles to state coverage of these low-income children by imposing restrictions that are wholly inconsistent with the spirit and the letter of the law. Where the statute and HHS' own regulations contemplate discretion on the part of the states, CMS' letter takes it away. Where Congress' intent was to encourage expansive coverage, CMS' letter limits it. Had CMS adhered to the rulemaking requirements of the Administrative Procedure Act before issuing this letter, states would have had the opportunity to comment on the proposal and share their concern that the new requirements are so onerous that they will effectively undermine the states'

efforts to provide health care to some of their most vulnerable citizens. As it stands, CMS engaged in unlawful rulemaking, far beyond the scope of existing statutory and regulatory requirements.

The amici states, on behalf of the administrators of each state's SCHIP program, have a critical interest in ensuring that the rules under which they deliver health insurance to their needier children are fair, consistent and applied in accordance with the governing statute and regulations. The amici also have a compelling interest in ensuring that these children have access to the services to which they are entitled by law and that states benefit from the funding to which they are entitled. If CMS' letter is implemented, the fate of health insurance for thousands of low-income children in California, Connecticut, Massachusetts and New Mexico will be at risk.[1]

OVERVIEW OF THE SCHIP PROGRAM AND CMS' AUGUST 17 LETTER

When Congress enacted the SCHIP program in 1997 as Title XXI of the Social Security Act (Act), Pub. L. No. 105-33, 42 U.S.C. §§ 1397aa-1397jj (2000), it authorized federal reimbursement to the states for a percentage of their "child health assistance" expenditures made pursuant to the state's federally-approved SCHIP state plan. 42 U.S.C. § 1397ee. An outgrowth of the Medicaid program, SCHIP was intended to provide health insurance to "targeted low-income children," i.e., children living in low-income families who nonetheless fall above Medicaid eligibility limits. The SCHIP statute specifically allows each state to determine eligibility rules, including those related to income and resources. 42 U.S.C. § 1397bb(b).

[1] While CMS' letter has no immediate impact on New Mexico, where it covers children only up to 235 percent of the FPL, it joins in this matter because it believes that the letter unlawfully and unfairly restricts the state in its ability to amend its state plan should it wish to do so in the future.

Mirroring the statutory grant of discretion, the SCHIP regulations provide that "[w]ithin broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures." 42 C.F.R. § 457.1 (2007).

In enacting SCHIP, Congress was concerned that the federal investment in children's health insurance would have the broadest possible impact. For this reason, Congress sought to avoid merely shifting already-insured children from employer-sponsored plans onto federally-subsidized plans. To ensure that the SCHIP program provided federal matching dollars on health coverage only for those without other coverage options, the SCHIP statute and implementing regulations required states to adopt "reasonable procedures" to ensure that public coverage does not substitute for, or "crowd-out," private, employer-sponsored group insurance plans. 42 C.F.R. § 457.805.

Following the federal Act's passage, California, Connecticut, Massachusetts and New Mexico, like all other states, enacted their own state SCHIP programs to provide health insurance to their "targeted low-income children." Cal. Ins. Code § 12693 et seq. (West 2007), Conn. Gen. Stat. § 17b-292 (West 2008); Mass. Gen. Laws ch. 118E, § 16C (West 2008), N.M. Stat. Ann. § 27-2-12 (West 2008). In accordance with the discretion granted to them by the federal statute, and with approval by HHS, Connecticut and Massachusetts chose to extend health insurance coverage to children living in families with incomes up to 300 percent of the FPL. Likewise, California extended coverage to children in families up to 300 percent of the FPL in a limited number of circumstances. As required by statute and regulation, the amici states also adopted effective crowd-out procedures, which have been consistently approved by CMS.

With its August 17, 2007 letter, CMS exceeded its powers by imposing new requirements on the states and substantially changing the rules governing the provision of SCHIP health

coverage to "children in families with effective family income levels above 250 percent of the Federal poverty level."[2] Reflecting its concern about "the potential for crowd-out" with higher income beneficiaries, CMS announced new rules for states that cover these children. Issued without the benefit of the requisite notice and comment process, the letter requires that affected states now include specific crowd-out strategies in their state plans, including:

> (1) assuring that at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for SCHIP or Medicaid are enrolled;
>
> (2) assuring that the number of children in the target population insured through private, employer-sponsored plans has not decreased by more than two percentage points over the prior five-year period;
>
> (3) preventing employers from changing their dependent coverage obligations on the part of families;
>
> (4) requiring a minimum of a one-year period of uninsurance for individuals prior to obtaining insurance through SCHIP; and
>
> (5) adopting cost-sharing requirements that are comparable (within one percent of the family income) to those charged by competing private plans, unless the state plan's cost-sharing is set at the statutory five percent cap.

The letter indicates that CMS "expect[s]" affected states to amend their SCHIP state plans within

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[2] A copy of the letter is attached hereto as Exhibit 1. The applicability of the letter is unclear due to CMS' use of the term "effective family income," when the Act and implementing regulations apply only to "targeted low-income children." Because neither the Act nor the regulations defines "effective," and the definition does not appear in CMS' letter, it is ambiguous as to how broadly and to whom the letter applies. CMS officials have advised some states that "effective" family income means gross income, while other states are operating under the impression that effective income connotes a family's net income.

12 months. Should states fail to do so, "CMS may pursue corrective action."[3]

With the imposition of these additional requirements, the letter imposes new and substantive obligations on the states, significantly limits their discretion and represents a significant departure from longstanding agency policy. As such, the letter constitutes a legislative rule, which should have been promulgated in accordance with the notice and comment requirements of the Administrative Procedure Act. 5 U.S.C. § 553 (2000).

To determine whether a rule is legislative or interpretive, courts focus on the intended legal effect of the rule, not the stated intent of the agency. See General Motors Corp. v. Ruckelshaus, 742 F.2d 1561, 1565 (D.C. Cir. 1984). Thus, "where necessary, the court will look behind the particular label applied by the agency . . . in order to discern its real intent and effect." Batterton v. Marshall, 648 F.2d 694, 705 n.58 (D.C. Cir. 1980). Legislative rules are those that "create new law, rights, or duties" and are intended to "bind members of the agency and the public." Sweet v. Sheahan, 235 F.3d 80, 91 (2d Cir. 2000). These types of rules are subject to the Administrative Procedure Act because "notions of fairness and informed administrative decisionmaking require that agency decisions be made only after affording interested persons notice and an opportunity to comment." Chrysler Corp. v. Brown, 441 U.S. 281, 316 (1979).

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[3] The letter imposes additional terms as well, requiring that states monitor and verify a family's health insurance status and report crowd-out data on a monthly basis. The letter is unclear as to whether verification of an applicant's insurance status must precede a determination of eligibility, a requirement that would delay the availability of health insurance for affected children. It is also unclear whether CMS intends the monthly reporting requirement to replace the existing requirement that directs programs to file "crowd-out" reports on a quarterly and annual basis. All these requirements make the provision of coverage to low-income children more difficult, are inconsistent with the purposes of the program and should have been subject to rulemaking. Until now, CMS has consistently approved the amici states' plan provisions on these matters.

Contrary to CMS' assertion, this letter cannot be classified as interpretive, as it does far more than simply clarify existing "reasonable procedures" with which states currently comply. Rather, the letter's requirements constitute substantive changes that go well beyond the scope of existing statutory and regulatory requirements. Thus, because this letter was issued without notice and comment, it is invalid.[4]

As a practical matter, the effect of the letter is to deprive states of federal funding for their coverage of thousands of low-income children because the letter imposes requirements so onerous that affected states will simply be unable to comply with all of them. To receive federal funding under the new standard, for example, states will be required to enroll 95 percent of their low-income children (a percentage matched only by Medicare, which has automatic enrollment) and will be held accountable for an employer's past coverage decisions. States are not in a position to do either.

ARGUMENT

I. THE EFFECT OF CMS' LETTER IS TO DENY FUNDING FOR HEALTH CARE SERVICES FOR THOUSANDS OF NEEDY CHILDREN ACROSS THE STATES.

If California, Connecticut and Massachusetts are required to comply with all the requirements of the August 17 letter, the states will, in all likelihood, lose federal funding for health insurance for thousands of low-income children as the failure to comply subjects them to CMS enforcement actions that could potentially deny all federal reimbursement to the states

[4] For example, in Am. Frozen Foods Inst. v. United States, 855 F.Supp. 388 (Ct. of Int'l. Trade 1994), the statute imposed a duty on importers to conspicuously mark food containers. Id. at 391. Customs imposed new, specific labeling requirements in applying this statute. The court concluded that the detailed and restrictive requirements imposed by Customs did not interpret the statute, but rather imposed additional obligations on food importers and therefore violated the Administrative Procedure Act. Id. at 396.

under SCHIP. 42 U.S.C. § 1397ff; 42 C.F.R. § 457.200 et seq.[5] Faced with this loss, the states may be forced to eliminate the health care assistance benefits that they currently provide to such children. Alternatively, the states may elect to continue providing such assistance, at entirely state expense. In that case, the funds that each state is required to expend to compensate for the loss of federal reimbursement will negatively affect its ability to provide other necessary governmental services and benefits.

A. California's Federally-Approved SCHIP State Plan

California implemented its SCHIP program in 1998, and administers it as a combination Medicaid expansion and separate SCHIP program. Cal. Ins. Code § 12693 et seq. California runs the largest SCHIP program in the country, accounting for about 16 percent of all federal SCHIP dollars in the 2007 federal fiscal year. The number of children covered in California exceeds the combined total of children served by New York and Texas, the country's second and third largest programs. Since 1998, California has amended its state plan twelve times; CMS has approved each amendment, most recently in March 2006.

Generally, California's SCHIP program provides health insurance to children living in families with incomes up to 250 percent of the FPL who are otherwise ineligible for "no share of cost" Medicaid. However, the program extends coverage up to 300 percent of the FPL for children up to age two born to mothers participating in the Access for Infants and Mothers program, and for children living in three counties (San Mateo, Santa Clara and San Francisco) that spend their own local funds to cover children between 250 and 300 percent of the FPL.

As of late 2007, approximately 866,000 children participate in California's SCHIP program. Of those, over 18,000 children live in families with incomes between 250 and 300

[5] As noted above, New Mexico is not presently threatened with the loss of federal funding.

percent of the FPL, although some of these children may experience more than one period of enrollment during the year. Overall, the state expended $350 million on the program in fiscal year 2007 and received approximately $600 million in federal SCHIP funds.

In determining eligibility for its SCHIP population, California calculates a family's income based on its net household income. The state excludes certain income from the calculation by using income deductions derived from the state's Medicaid program. It also allows a disregard, i.e., an amount not included in a family's countable income for purposes of determining eligibility, for all income between 200 and 250 percent of the FPL. Cal. Ins. Code § 12693.70(a)(6)(B), (C). CMS has consistently approved this income counting methodology and the children who live in families with net incomes under 250 percent of the FPL should be unaffected by the CMS letter. Yet because CMS has not defined the term "effective family income" in its August 17 letter, it is possible that a number of California children currently considered below 250 percent of the FPL may exceed the threshold.

B. Connecticut's Federally-Approved SCHIP State Plan

Connecticut's original SCHIP state plan was federally-approved by CMS on April 27, 1998, effective retroactive to January 1, 1998. Connecticut's state plan builds on its federally approved Medicaid state plan by covering children who are ineligible for assistance under Medicaid due to too much family income. Because Connecticut's Medicaid program covers all children with family incomes up to 185 percent of the FPL, that income level serves as the floor for Connecticut's SCHIP program. From the inception of the SCHIP program more than a decade ago, Connecticut's federally-approved SCHIP state plan has provided for the disregard of any family income between 235 and 300 percent of the FPL in determining eligibility for SCHIP.

As a result, children in families with gross incomes up to 300 percent of the FPL have been covered under the SCHIP state plan.[6]

As of April 1, 2008, approximately 15,900 children participate in Connecticut's SCHIP program, of whom almost 5,000 have gross family income that exceeds 250 percent of the FPL. If by "effective" income, CMS means net income, about 4,100 Connecticut children are affected by the CMS rule. If turnover within the program is factored in, the number of affected children may be closer to 7,500.

Connecticut expended almost $36 million on its SCHIP program in federal fiscal year 2007 and received approximately $23 million in federal reimbursement. Approximately $6 million of that amount was attributable to children in families with income over 250 percent of the FPL. The loss of such funding seriously undermines the state's continued ability to provide services.

C. Massachusetts' Federally-Approved SCHIP State Plan

Massachusetts implemented its SCHIP program in 1998, following enactment of Chapter 170 of the Acts of 1997, Mass. Gen. Laws ch. 118E, § 16C. The program is administered as a combination Medicaid expansion and separate SCHIP program. Medicaid covers children in families with incomes up to 150 percent of the FPL. Until 2006, the separate SCHIP program covered children living in families with incomes between 150 percent and 200 percent of the FPL, picking up where the Medicaid expansion coverage left off.

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[6] Connecticut has amended its SCHIP state plan several times in the intervening years, but never with respect to income disregards. The disregards have remained in place, unchallenged by CMS for more than a decade. Moreover, Connecticut's coverage of children in families up to 300 percent of the FPL has been codified into state law. Conn. Gen. Stat. § 17b-292(a). Thus, Connecticut cannot come into compliance with the August 17 letter merely by administratively amending its SCHIP state plan.

In 2006, with the passage of the Commonwealth's landmark health care reform legislation, Massachusetts' separate SCHIP program expanded coverage to include children with family incomes up to 300 percent of the FPL. This expansion was enacted as a central component of health care reform in an effort to provide health coverage to as many Massachusetts residents as possible. Ch. 58 of the Acts of 2006, § 26, Mass. Gen. Laws ch. 118E, § 16C (3). Like California and Connecticut, Massachusetts covers children with family income up to 300 percent of the FPL through the use of approved income disregards.

CMS approved this statutory expansion as part of the Commonwealth's most recent state plan amendment, which became effective July 1, 2006. Since that time, and relying on CMS' approval of the state plan, the Commonwealth has been able to make health coverage available to many more low-income children. As of February 2008, program enrollment has grown by 19,000 children as a result of the expansion. Of those 19,000 children, roughly 6,000 live in families with incomes between 250 and 300 percent of the FPL.

Massachusetts expended $327 million on its SCHIP program in federal fiscal year 2007, and received approximately $212 million in federal reimbursement. $9.3 million of that amount was attributable to children in families with income over 250 percent of the FPL. Accordingly, factoring in turnover, the loss of at least $9.3 million affects the ability of approximately 11,000 Massachusetts children to receive health care coverage in a year. Particularly in Massachusetts, where adequate funding of each component of the state's health reform is critical to its success, the loss of federal funding will have an enormous impact.

D. New Mexico's Federally Approved SCHIP State Plan

New Mexico implemented its SCHIP program in 1999, as an expansion of its existing Medicaid program. N.M. Stat. Ann. § 27-2-12. The program, administered by the New Mexico

Human Services Department Medical Assistance Division, covers children in families with incomes up to 235 percent of the FPL.

Since implementation, CMS has consistently approved New Mexico's state plan, most recently in September 2007. Pursuant to the plan, New Mexico imposes co-payments on participants in the SCHIP program, with the exception of Native Americans, and imposes a six-month waiting period before a child previously insured through other means may become eligible for SCHIP.

As of March 2008, New Mexico serves approximately 9,700 children through its SCHIP program. In federal fiscal year 2007, the state expended $62 million on its SCHIP program and received approximately $50 million in federal reimbursement.

Unlike the other amici states, the CMS letter has yet to have a direct impact on New Mexico's current program. However, in the near future, New Mexico may wish to implement program changes with regard to income eligibility determinations and crowd-out provisions. Any such changes would be affected by the CMS letter, and the limitations imposed by the letter may deny coverage to large numbers of New Mexico's neediest children.

II. THE REQUIREMENTS OF THE CMS LETTER ARE INCONSISTENT WITH THE SCHIP STATUTE AND REGULATIONS AND THUS CONSTITUTE UNLAWFUL RULEMAKING.

The provision of federal SCHIP funds to the states for the health coverage they provide to uninsured "targeted low-income children" is dependent upon the state's submission of a state plan that meets the Act's statutory and regulatory requirements. Assuming that the state's plan meets those criteria, it is entitled to receive capped federal reimbursement for a percentage of the

expenditures it incurs in providing "child health assistance" benefits to eligible children.[7] Two such criteria, of central importance in this matter, are (1) the state's determination of program eligibility on the basis of family income and (2) the state's development of "reasonable procedures" to prevent crowd-out. Historically, CMS has consistently approved the amici states' treatment of these criteria. However, the August 17 letter makes it clear that such approval will no longer be forthcoming.

A. CMS' Letter Is Inconsistent with Congress' Intent to Grant States Discretion in Making Income Determinations for Their SCHIP Programs.

Given the almost insurmountable barriers imposed by the August 17 letter, the amici states question whether the letter reflects not only the agency's concern about "crowd-out" but perhaps, more fundamentally, a view that states should be restricted in their practice of covering children at the higher end of the low-income spectrum.[8] This view is wholly inconsistent with what Congress intended and it imposes unnecessary obstacles to the efforts of states with high costs of living such as California, Connecticut and Massachusetts to make affordable health insurance available to all children.

When Congress enacted SCHIP, it intentionally gave states wide discretion in determining how income will be counted for eligibility purposes. Each state's child health plan

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[7] States are not reimbursed solely on the basis of their expenditures. To the contrary, the amount that each state receives is capped by its allotted share of block grant funds that are made available each year by Congress. A state's allotment of the total block grant funding is determined by a statutory formula that takes into account a number of factors, including the number of low income uninsured children in the state. 42 U.S.C. § 1397dd. Thus, in addition to the administrative supervision provided by CMS, Congress can indirectly control the state's exercise of discretion under the Act by controlling the amount of the annual appropriation.

[8] A review of the Administration's budget for FY 2009 lends credence to this view. As proposed, the Administration would target SCHIP funds to children with family incomes below 200 percent of the FPL and establish a "hard cap" for SCHIP eligibility at 250 percent of the FPL based on a family's gross income, without accounting for income disregards.

is required to describe "the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan." 42 U.S.C. § 1397bb(b)(1)(A). The term "targeted low-income children" is defined expansively so as potentially to include children from families with incomes over 200 percent of the FPL. Specifically, 42 U.S.C. § 1397jj(b)(1) reads as follows:

> . . . [T]he term "targeted low-income child" means a child –
>
> > (A) who has been determined eligible by the State for child health assistance under the State plan;
> > (B) (i) who is a low-income child, or
> > (ii) is a child –
> > (I) whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level . . . , but does not exceed 50 percentage points above the Medicaid applicable income level . . . (emphasis added).

Congress specifically defined the term "targeted low-income child" (1) to allow the use of an income limit of 50 percentage points higher than the applicable Medicaid income level for children in the state (in lieu of the 200 percent of the FPL standard inherent in the definition of a "low income child") and (2) to authorize explicitly a state's discretion to compute family income in the manner specified by the state in its SCHIP state plan. CMS regulations mirror the statute, defining a "targeted low-income child" as a child with family income either at or below 200 percent of the FPL or 50 points higher then the state's Medicaid income eligibility limit for children. 42 C.F.R. § 457.310. The term "family income" is defined as meaning "income as determined by the State ..." 42 C.F.R. § 457.10.

By these very terms, Congress and CMS recognized the states' authority to provide coverage to children in families with incomes over the cap that CMS now imposes. Through the use of income counting methodologies that disregard specified types and amounts of income, states were granted wide latitude in determining a family's countable income for eligibility

purposes.[9] Any suggestion by CMS that the states are administering the program improperly by covering higher income children is unfounded. To the contrary, the regulations appropriately give high cost of living states the flexibility to adapt their SCHIP programs to individual state needs. CMS has repeatedly approved the SCHIP state plans of California, Connecticut and Massachusetts, as well as many other states that cover children in these higher income brackets.[10] Even now, CMS does not directly call for the outright prohibition on states covering such children. Instead, it seeks to impose requirements that, as a practical matter, will make such coverage impossible.

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[9] Consistent with its approach to other public assistance programs, Congress afforded states discretion to determine how income is to be determined in the SCHIP program. SCHIP builds on the Title XIX Medicaid program by allowing the coverage of children whose family income exceeds the Medicaid income eligibility limit but, as determined by the state, is below specified levels. In the Medicaid context, Congress addressed the income counting dilemma by generally providing that the states must use the "same methodology" as is employed in the most closely related federal-state "cash assistance" program. For children, this is the former Aid to Families with Dependent Children (AFDC) program, codified at Title IV A of the Social Security Act. 42 U.S.C. § 1396a(r)(2)(A). The former AFDC program, now replaced by the Temporary Assistance to Needy Families program, required that certain deductions be taken from gross income for purposes of determining eligibility, and allowed other deductions to be taken at state election. Furthermore, if a state wished to be more liberal than AFDC in its income counting methodologies, the Medicaid Act expressly allows the states to employ "less restrictive methodologies" in their programs. 42 U.S.C. § 1396a(r)(2)(A); 42 C.F.R. § 435.601(d). Thus, the use of income counting methodologies, including income disregards, is expressly allowed in the Medicaid program, on which SCHIP is based.

[10] As of December 2007, at least eleven states cover children with family incomes over 250 percent of the FPL. In addition, Rhode Island and Washington, as well as California, currently set their income eligibility limits at 250 percent of the FPL and may be affected by the CMS letter because they use various deductions to calculate "net income." Four other states have curtailed coverage expansions due to the letter. Cindy Mann and Michael Odeh, Ctr. for Children and Families, Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children (Dec. 2007) available at http://ccf.georgetown.edu/index/moving-backward-status-report-of-aug-17-2007-directive?highlight=moving%20backward.

B. CMS' Letter Is Inconsistent with Congress' Intent to Grant States Discretion in Devising Their Own "Crowd-Out" Provisions, and Its Own Regulations.

Similarly, the SCHIP Act and its implementing regulations direct participating states to devise "crowd-out" provisions but do not dictate the form such provisions must take. By "crowd-out," CMS means the substitution of government subsidized health coverage under SCHIP for coverage that would otherwise be available to the child under employer-sponsored, group health plans. Specifically, the Act requires only that states include in their SCHIP state plans:

> . . . a description of procedures to be used to ensure –
>
> . . .
>
> (c) that the insurance provided under the State child health plan does not substitute for coverage under group health plans . . .

42 U.S.C. § 1397bb(b)(3)(C). In addition, states are to include within their annual reports to CMS an assessment of whether their programs result in "crowd-out." 42 U.S.C. § 1397hh. The implementing regulations similarly require SCHIP state plans to include "a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans . . ." 42 C.F.R. § 457.805. Accordingly, the SCHIP Act and its implementing regulations afford the states wide discretion to determine their own "reasonable" crowd-out procedures. CMS' attempt to prescribe specific, mandatory crowd-out procedures in the letter is inconsistent with this grant of discretion.[11]

[11] The only circumstance in which CMS imposes specific, mandatory crowd-out procedures is in the administration of state premium assistance programs. See 42 C.F.R. § 457.810. CMS cannot, by mere letter, add a series of new, mandatory requirements applicable to coverage for a specific class of children (those in families with "effective" income over 250 percent of the FPL). If CMS wishes to impose mandatory requirements beyond those already adopted by regulation, it must amend the existing regulations through proper notice and comment rulemaking.

III. CMS' NEW CROWD-OUT REQUIREMENTS ARE UNLAWFUL AND WILL UNDERMINE THE STATES' CONTINUED ABIILITY TO PROVIDE HEALTH BENEFITS TO THEIR NEEDY CHILDREN.

According to its August 17, 2007 letter, CMS "will expect" each state with "an effective [income eligibility] level of 250 percent of the FPL" to adopt the specific crowd-out procedures identified in the letter. Should states fail to amend their SCHIP state plans accordingly, CMS may pursue corrective action."[12] The CMS letter makes it essentially impossible for states to cover children with family incomes higher than 250 percent of the FPL.

For California, Connecticut and Massachusetts, this denial translates into thousands of affected children. For the programs themselves, the requirements of the letter create an unnecessary administrative burden where the states already have CMS-approved procedures in place to address this issue and there is no evidence to support the notion that limiting eligibility prevents crowd-out. To the contrary, evidence suggests that, if anything, expanding eligibility has a positive impact on increased participation rates among previously eligible, lower income children.[13] Moreover, despite being added under the rubric of crowd-out, several of the

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[12] The CMS letter states that "[w]e would not expect any effect on current enrollees from this review strategy . . . ," apparently authorizing the "grandfathering" of current enrollees. It must be noted, however, that the turnover rate for children assisted under the program is high, with all of the amici states experiencing a rate of at least 50 percent. Any "grandfathering" of current children will not prevent thousands of new children applying for assistance from being harmed, or prevent the states from experiencing the loss of federal revenue that they are entitled to receive.

[13] Mann and Odeh, supra at 4. See also Teresa A. Coughlin and Mindy Cohen, The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured, A Race to the Top: Illinois's All Kids Initiative (Aug. 2007), available at http://www.kaiserfamilyfoundation.org/uninsured/7677.cfm.

requirements have little to do with crowd-out, or the "reasonable procedures" intended to prevent it.[14]

A. The Requirement That States Provide Assurance That They Have Enrolled At Least 95 Percent of the Medicaid or SCHIP-Eligible Children in the State Below 200 Percent of the Federal Poverty Is Unlawful.

According to the August 17 letter, a state will only be permitted to cover children at the higher income levels if it provides an assurance that it has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for either SCHIP or Medicaid. Despite CMS' claim that this assurance somehow serves to prevent crowd-out among higher income children, the requirement only addresses how effective the state has been in enrolling lower income children in the program. In other words, it relates to the outcome achieved, not to the reasonableness of the procedures employed. CMS' characterization of this requirement as a clarification of the existing "reasonable procedures" requirement is inaccurate.

CMS' letter asks the impossible. The *only* health insurance program that comes close to reaching 95 percent enrollment is the Medicare program, which has automatic enrollment. Thus, no matter how diligent a state's efforts, the 95 percent enrollment is tantamount to a prohibition on covering children with family incomes over 250 percent of the FPL.[15]

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[14] For a discussion of the letter's implications for the states generally, see Covering Uninsured Children: The Impact of the August 17th CHIP Directive: U.S. Senate Finance Subcommittee on Health Care (April 9, 2008) (statement of Alan Weil, National Academy for State Health Policy), available at http://finance.senate.gov/hearings/testimony/2008test/040908awtest.pdf. A copy of the statement is attached hereto as Exhibit 2.

[15] "No means-tested program where people have to apply and be reviewed for eligibility has reached this high standard of participation." Mann and Odeh, supra note 8, at 2. The low-income subsidy for the Medicare Part D benefit achieves a participation rate of only approximately 43 percent. Nationally, participation rates for SCHIP and Medicaid approximate 63 and 79 percent, respectively. Id.

One of the most effective means of increasing program enrollment is to engage in extensive outreach. To this end, participating states are, by law, required to engage in outreach and coordination with other health insurance programs. 42 U.S.C. § 1397bb(c). California, Connecticut, Massachusetts and New Mexico employ aggressive outreach efforts, all of which have been approved by CMS in their state plans. For example, all the states operate extensive "out station locations," use a simplified application process, and assist applicants with necessary paperwork. To date, CMS has never questioned the adequacy of the amici states' outreach efforts.[16]

Moreover, the 95% enrollment requirement is problematic because a number of eligible low-income children will not be covered by an assistance program no matter how vigorous a state's outreach efforts. Families fall in and out of poverty (and, therefore, in and out of eligibility requirements) as a result of a host of factors, including the death of the employed parent, divorce and job loss. Yet, they do not necessarily apply for health care assistance for their children as soon as they lose a job or experience a death or divorce, but wait out of hope that their circumstances will improve. Parents who are illiterate or who do not speak English may be less likely to apply for assistance, no matter how diligent the state's outreach efforts.

Finally, no solid data on enrollment levels exist. CMS has not specified in its letter the data source it will use or how it will gauge whether states have met the 95 percent benchmark.

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[16] Despite CMS' stated concern about the adequacy of the states' efforts to enroll lower income children in Medicaid and SCHIP, it recently issued regulations that will significantly curtail state outreach efforts in an area that has been the most successful, i.e., arrangements with local public schools to enroll lower income children in Medicaid. The rule became final on December 28, 2007; a moratorium on its implementation is scheduled to expire on June 30, 2008. See Judith Solomon and Donna Cohen Ross, Ctr. on Budget and Policy Priorities, Administration Moves to Eviscerate Efforts to Enroll Uninsured Low-Income Children in Health Coverage Through the Schools (Oct. 1, 2007), available at http://www.cbpp.org/9-17-07health.htm.

State agencies are familiar with the children who apply for and receive assistance from their programs but they do not have first-hand knowledge of the number, eligibility or circumstances of children under 200 percent of the FPL who have *not* applied for assistance. The only current source of related data is that compiled by the Current Population Survey (CPS). That body of data, however, only measures children *covered by*, not *eligible for*, SCHIP or Medicaid. CMS has also failed to identify the point in time at which enrollment is to be measured, i.e., a fixed point in time during the year, during any particular month of the year, or some other measure.[17] In the absence of authoritative guidance from CMS, it is impossible for the amici states to even attempt compliance with this requirement.[18]

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[17] Moreover, because the CPS data addresses the total number of children under 200 percent of the FPL but does not address the eligibility of those children for public assistance programs, it is of limited utility for purposes of providing the required assurance. The data's reliability is also questionable. See Congressional Budget Office, The State Children's Health Insurance Program (May 2007) 9, available at http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf; (Coverage in public programs such as Medicaid is underreported . . ."); Genevieve M. Kenney, The Urban Institute, Medicaid and SCHIP Participation Rates: Implications for New CMS Directive (Sept. 2007), available at http://www.urban.org/Uploaded F/411543_Medicaid_Schip.pdf (". . . there are serious methodological challenges associated with obtaining valid state-level participation rate estimates given the currently available data.")

[18] While CMS officials have made oral representations to Connecticut and Massachusetts that their programs might satisfy the 95 percent enrollment requirement and have recently testified that they "suspect" that a number of states are meeting the threshold, none of the states have received any official communication from CMS on this point. (Statement of Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, before the U.S. Senate Finance Subcommittee on Health Care (April 9, 2008)). CMS has not provided any of the states with a written acknowledgement that the state has satisfied the requirement. Thus, the states are placed in the untenable position of hoping that CMS' "suspicion" prevails while still being held to the requirements of the letter. (Based on the methodology that CMS has employed as recently as August 2007, 41 of the 50 states, including California, Connecticut, Massachusetts and New Mexico achieved the required 95 percent participation rate, with many exceeding a rate of 100 percent. However, the methodology, while favorable to the states, has been soundly criticized. Kenney, supra at 2-4.) The fact that New York, which was on the list of compliant states, had its state plan denied in part because of its failure to meet the enrollment requirement, underscores the validity of the amici states' concerns.

Had CMS complied with the rulemaking requirements, the states would have had the opportunity to express these concerns.

B. States Have Little Control Over Whether the Number of Children in the Target Population Insured Through Private Employers Has Decreased by More Than Two Percent Over the Previous Five-Year Period.

The requirement that states be able to establish that the number of children in the target populations insured through private employers has not decreased by more than two percent over a five-year period imposes an unfair and overwhelming burden on the amici states. First, this assurance cannot be said to constitute a "clarification" of the reasonable crowd-out procedures that state agencies are required to adopt, as it does not mandate that states either take any particular action or utilize any particular procedure to deter crowd-out.[19]

Second, CMS is asking state agencies to assume responsibility for the coverage decisions of private employers made in a previous five-year period. Employer coverage has declined sharply for all groups of Americans, including children. It is unreasonable to expect state agencies to somehow alter this trend.[20]

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[19] The August 17 letter does not define the term "target population," leaving it unclear as to whether the term refers to children with "effective" family income over 250 percent of the FPL who are eligible under the state's SCHIP program, children under 200 percent of the FPL as suggested by CMS, or some other "target" group of eligible children.

[20] Between 2000 and 2006, rates of employer-sponsored coverage fell four percentage points for non-elderly adult workers and almost nine percentage points for all children under 18, irrespective of income. See Paul Frontsin, Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey (Oct. 2007), available at http://www.ebri.org/publications/ib/index.cfm?fa= i.e., amounts not included in a family's countable income for purposes of determining eligibility main&doc_type=1.

C. States Face Difficult Hurdles in Preventing Employers from Changing Dependent Coverage Policies in a Manner That Would Favor a Shift to Public Coverage.

The August 17 letter's requirement that states "prevent[] employers from changing dependent coverage policies that would favor a shift to public coverage" poses an insurmountable burden for state Medicaid and state health agencies. As a practical matter, requirements preventing employers from changing their benefit plans by dropping health care coverage for dependents can only be adopted by statute, rather than by agency action. Moreover, the Employment Retirement Income Security Act, 29 U.S.C. § 1144(a), may create obstacles to the passage of state laws that attempt to prescribe benefits that must be provided by employer-sponsored benefit plans. See FMC Corp. v. Holliday, 498 U.S. 52 (1990); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 733 (1985); Delta Air Lines, Inc. v. Kramarsky, 725 F.2d 146, 147 (2d Cir. 1981).

D. The Letter's Required One-Year Waiting Period of Uninsurance Is Unlawful to the Extent That It Recognizes No Exceptions and, Even with Exceptions, Would Require Rulemaking.

The one-year waiting period imposed by the CMS letter cannot be justified as an "interpretation" of the statutory requirement that SCHIP not substitute for coverage under group health plans because the waiting period applies without regard to whether coverage under a group health plan is available. Instead, the only effect of the requirement is to deny health care coverage to thousands of children who, in fact, have no access to employer-sponsored health insurance and to deny federal reimbursement to the states for the assistance that they provide these children pursuant to their SCHIP programs. Debilitating life-threatening illnesses do not wait for the mandatory, one-year waiting period prescribed by CMS. Moreover, in a complete departure from its regulations, CMS' letter recognizes no exceptions to the waiting period requirement. The amici states already impose waiting periods of less than one year, with the

requisite exceptions, as part of their reasonable crowd-out procedures.[21] No need has been demonstrated for the imposition of a longer period of time.

E. The Letter's Cost-Sharing Requirements Will Discourage Program Participation and Are Contrary to the Intent of the Statute.

The letter's call for what will inevitably result in increased cost-sharing on the part of families is ill-advised and unwarranted. CMS' letter requires that, for children in families with incomes over 250 percent of the FPL, the cost-sharing imposed under SCHIP must be comparable to that which would be imposed under "competing private plans," unless the SCHIP cost-sharing amount is already set at the five percent family cap. This requirement is problematic for several reasons. First, CMS does not define the term "competing private plans," again leaving the states in the position of trying to determine what is required of them. Second, even were that term defined, the states may simply not have the data available to them to conduct the comparison that the letter requires and the plans may decline to provide it as confidential. Thus, cost-sharing would revert to the five percent cap. Finally, while all of the amici states impose cost-sharing on program participants, none charge amounts that approximate the levels charged in the private sector or at five percent of a family's income. Imposing SCHIP cost-

[21] Most other states will be similarly affected by the new one-year waiting period requirement, as few states impose such a lengthy waiting period. See Donna Cohen Ross and Aleya Horn, Center on Budget and Policy Priorities and Caryn Marks, Kaiser Commission on Medicaid and the Uninsured, Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles (Jan. 2008), available at http://kff.org/medicaid/upload/7740.pdf.

sharing at either of these levels will inevitably lead to reduced participation and utilization.[22] Such a result is antithetical to SCHIP's purpose of meeting the needs of low-income children. Had CMS adhered to the required rulemaking requirements, the states could have expressed these concerns.

CONCLUSION

For all of the foregoing reasons, the States of California, Connecticut, Massachusetts and New Mexico urge the Court to deny the United States' motion to dismiss and to grant the plaintiff States' motion for summary judgment. Decisions of fundamental importance, affecting the ability of the states to provide federally-subsidized child health care assistance to targeted low-income children, need to be made through deliberative processes that include notice and comment.

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[22] See Donna Cohen Ross and Aleya Horn, Center on Budget and Policy Priorities and Caryn Marks, Kaiser Commission on Medicaid and the Uninsured, Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles 8 (Jan. 2008), available at http://kff.org/medicaid/upload/7740.pdf, citing Samatha Artiga and Molly O'Malley, Kaiser Commission on Medicaid and the Uninsured, Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences (May 2005), available at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261.

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EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

August 17, 2007 SHO #07-001

Dear State Health Official:

This letter clarifies how the Centers for Medicare & Medicaid Services (CMS) applies existing statutory and regulatory requirements in reviewing State requests to extend eligibility under the State Children's Health Insurance Program (SCHIP) to children in families with effective family income levels above 250 percent of the Federal poverty level (FPL). These requirements ensure that extension of eligibility to children at these higher effective income levels do not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage to the core SCHIP population of uninsured targeted low income children.

Section 2101(a) of the Social Security Act describes the purpose of the SCHIP statute "to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage." Section 2102(b)(3)(C) of the Act, and implementing regulations at 42 CFR Part 457, Subpart H, require that State child health plans include procedures to ensure that SCHIP coverage does not substitute for coverage under group health plans (known as "crowd-out" procedures). In addition, section 2102(c) of the Act requires that State child health plans include procedures for outreach and coordination with other public and private health insurance programs.

Existing regulations at 42 C.F.R. 457.805 provide that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage. In issuing these regulations, CMS indicated that, for States that expand eligibility above an effective level of 250 percent of the FPL, these reasonable crowd-out procedures would include identifying specific strategies to prevent substitution. Over time, States have adopted one or more of the following five crowd-out strategies:

- Imposing waiting periods between dropping private coverage and enrollment;
- Imposing cost sharing in approximation to the cost of private coverage;
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases; and/or
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

As CMS has developed more experience and information from the operation of SCHIP programs, it has become clear that the potential for crowd-out is greater for higher income beneficiaries. Therefore, we are clarifying that the reasonable procedures adopted by States to prevent crowd-out pursuant to 42 C.F.R. 457.805 should include the above five general crowd-out strategies with certain important components. As a result, we will expect that, for States that expand eligibility above an effective level of 250 percent of the FPL, the specific crowd-out

strategies identified in the State child health plan to include all five of the above crowd-out strategies, which incorporate the following components as part of those strategies:

- The cost sharing requirement under the State plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family cap;
- The State must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage; and
- Monitoring and verification must include information regarding coverage provided by a noncustodial parent.

In addition, to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage, and to prevent substitution of SCHIP coverage for coverage under group health plans, we will ask for such a State to make the following assurances:

- Assurance that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps the State takes to enroll these eligible children);
- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period; and
- Assurance that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

We will continue to review all State monitoring plans, including those States whose upper eligibility levels are below an effective level of 250 percent of the FPL, to determine whether the monitoring plans are being followed and whether the crowd-out procedures specified in the SCHIP state plans are reasonable and effective in preventing crowd-out.

CMS will apply this review strategy to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations, and will work with States that currently provide services to children with effective family incomes over 250 percent of the FPL. We expect affected States to amend their SCHIP state plan (or 1115 demonstration) in accordance with this review strategy within 12 months, or CMS may pursue corrective action. We would not expect any effect on current enrollees from this review strategy, and anticipate that the entire program will be strengthened by the focus on effective and efficient operation of the program for the core uninsured targeted low-income population. We appreciate your efforts and share your goal of providing health care to low-income, uninsured children through title XXI.

If you have questions regarding this guidance, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs, who may be reached at (410) 786-5647.

Sincerely,

/s/
Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
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EXHIBIT 2

NATIONAL ACADEMY
for STATE HEALTH POLICY

U. S. Senate Subcommittee on Health Care
Committee on Finance
"Covering Uninsured Children:
The Impact of the August 17th CHIP Directive"
April 9, 2008

Testimony of Alan Weil, JD, MPP
Executive Director
National Academy for State Health Policy (NASHP)

Chairman Baucus, Senator Grassley, Subcommittee Chairman Rockefeller, Senator Hatch, and members of the committee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization dedicated to working with state leaders to identify emerging issues, develop policy solutions and advance state health policy and practice. Since the inception of the State Children's Health Insurance Program (SCHIP) in 1997, NASHP has reported on and supported the work of states to implement and strengthen coverage of low-income children through SCHIP. Thank you for the opportunity to appear before you today to discuss CMS's August 17 SCHIP directive and its implications for states.

At the request of SCHIP directors in states affected by the directive, NASHP convened a workgroup to discuss the August 17 directive. Conference calls were held between January and March 2008 to allow states within the workgroup to discuss the directive, share information, and consider the potential implications of the directive's requirements. My testimony is based upon what we have heard from state officials who work closely with the SCHIP program but I do not purport to speak on behalf of the states.

In my testimony I will make three points. First, because the directive was written and issued without any input from states, it includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd out. Second, the CMS directive usurps Congressional authority with respect to both SCHIP and Medicaid. And third, the directive adds yet another level of uncertainty to states in a manner that impedes state action designed to achieve the statutory goal of reducing the number of children without health insurance.

Lack of Input Yields Flawed Directive

On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) released a letter to state health officials (SHO #07-001) directing significant changes in policy for SCHIP and children's health coverage. This directive was issued without any notice and comment period, without consultation with states, and was not issued as part of a formal rulemaking process. The requirements in the August 17 directive prompted questions and concerns among states, especially among the 24 states that are immediately affected due to current or recently approved eligibility levels. Because the directive was written and issued without any input from states, it includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd-out.

Although states have sought further guidance from CMS to address their concerns, CMS so far has not responded in writing to many of the detailed questions about the directive posed by individual states or to questions compiled from states by NASHP and submitted at the suggestion of CMS. Without further guidance, many states are struggling to determine whether they will be able to come into compliance. In many states, making the policy or eligibility changes that could

be required under the August 17 directive cannot happen overnight. States will need time to implement policy changes (including in some cases seeking legislative approval, rewriting forms, and reprogramming systems), to train workers, and to notify families who are enrolled or may apply of the new rules. Without further guidance from CMS, many states will likely be out of compliance when the guidance goes into effect on August 17, 2008.

As a result of our work with affected states, NASHP has identified four requirements in the August 17 directive as causing the greatest concern among states: 1) the 95 percent participation requirement; 2) the 12-month minimum waiting period; 3) the employer-sponsored insurance requirements; and 4) the cost-sharing requirements. These concerns are also discussed in a NASHP State Policy Briefing on this topic, which is being released today.

1. The 95 Percent Standard is Unattainable

CMS's directive requires states covering children with "effective" family income above 250 percent of the federal poverty level to assure that they have enrolled in SCHIP or Medicaid 95 percent of children from families with income below 200 percent of the federal poverty level.[i] While states share the goal of maximizing enrollment of eligible uninsured children, many are concerned this participation requirement will undermine ongoing efforts to cover more low-income children. They are concerned about the feasibility of measuring participation given the absence of reliable data, and they observe that experience from other programs demonstrates that this standard is unattainable.

Many states already are targeting efforts to cover children with family incomes below 200 percent of poverty. States expend significant resources on outreach to find and enroll these eligible children, and they have instituted a variety of measures to improve enrollment and

retention practices. The vast majority of children with family incomes below 200 percent of the federal poverty level who are eligible for either Medicaid or SCHIP are covered.[ii]

Additionally, a number of states that cover children with family incomes above 250 percent of the federal poverty level have found that increasing eligibility has been instrumental in reaching more eligible low-income children below 200 percent of the federal poverty level. For example, under Illinois' universal children's coverage program, AllKids, approximately 70 percent of the 166,000 children that were enrolled when the program started had been low-income children previously eligible for Medicaid and SCHIP but unenrolled. Establishing higher eligibility levels can reinforce the message that children can qualify even if their parents are working and earning low to moderate incomes.

Another significant challenge states face is the difficulty with measuring participation of low-income children. States cannot easily measure participation rates for SCHIP and Medicaid using available data sources. National surveys, such as the Census Bureau's Current Population Survey (CPS), have very small sample sizes for individual states, and many states view their own state estimates as a more accurate representation of the number of uninsured. In addition, survey respondents in the CPS tend to underreport Medicaid or SCHIP coverage (instead saying they have private coverage or are uninsured). Other surveys, such as the Survey of Income and Program Participation or the National Health Information Survey, do not contain recent enough data or have other limitations for measuring participation rates in SCHIP and Medicaid.

CMS has indicated in phone calls with states that it believes there are data approaches that could be used to demonstrate 95 percent coverage of eligible children, including modifications of the CPS to account for underreporting of Medicaid/SCHIP. If some states can develop methods to document 95 percent participation rates, there still may be concerns about

the policy and political implications of using different data for different purposes within a state and across states. Without consistent data definitions and sources, both state and federal policy makers will be denied the most consistent and valid data possible. In addition, some states worry about the potential long-term impact of showing compliance with the 95 percent standard using data or methods that are not accepted universally. By using less than rigorous data or methods, states could adversely impact future SCHIP funding, depending on the allocation formula used.

The 95 percent requirement appears arbitrary to states. CMS has not provided a rationale for selecting this figure. The participation rates for Medicaid and SCHIP are already higher than for most other voluntary programs targeting low-income Americans. Participation in the federal Food Stamp Program is approximately 50 percent, roughly 30 percent below the participation rate for SCHIP[iii]. Even in a program like Medicare Part B, in which seniors are enrolled automatically unless they opt-out, the participation rate is at 95.5 percent[iv]. Since no state has met this standard under CPS estimates or has yet successfully convinced CMS that it has reached the standard, many states believe it is unrealistic and unattainable.

2. The One Year Waiting Period Contradicts SCHIP Program Goals

CMS's directive requires states to establish – for children with family incomes above 250 percent of the federal poverty level – a minimum one year period of uninsurance before receiving coverage under SCHIP. Although requiring a period of uninsurance, also known as a waiting period, is not a new concept, states have had the flexibility to determine if a waiting period should be used and how long it should be. States have raised a number of concerns about the stringency of the new waiting period requirement related to its length and whether or not exceptions will be allowed.

In accordance with federal policy dating back to 2001,[v] states with SCHIP programs covering children with family income above 200 percent of the federal poverty level are responsible for monitoring, developing, and remaining ready, if necessary, to implement specific crowd-out prevention strategies.[vi] In addition, states with eligibility above 250 percent of the federal poverty level must have anti-crowd out strategies in place. Using the flexibility afforded through SCHIP, along with past experiences implementing strategies to deter crowd-out, states have policies in place that are aimed at reducing the likelihood of crowd-out in SCHIP programs.

According to NASHP's most recent state survey, the most frequently reported means used to deter crowd-out is a waiting period for children previously covered by a private insurance policy.[vii] Although it is unclear at this time how many states will be affected the by August 17 directive, 19 of the 24 states[viii] that either provide or propose to provide coverage to at least some children in families with gross incomes above 250 percent of the federal poverty level already use waiting periods. While the 19 states' waiting periods range from 1 month to 6 months, most states require between a 3- and 6-month waiting period between leaving private coverage and joining SCHIP.[ix] All of the states requiring waiting periods recognize that there may be reasons for losing private coverage that are beyond the family's control, so they allow exceptions to the waiting periods for circumstances such as death of a parent or involuntary loss of employment. By contrast, the August 17 directive does not discuss exceptions and CMS has not indicated whether any exceptions to the standard will be considered.

States are also concerned that the new waiting period could create substantial administrative complexity. For example, states that cover children above 250 percent might be forced to modify or create new applications to address the need for two different standards -- children in families with income above 250 percent of the federal poverty level will have a

longer period of uninsurance than those at lower incomes if states retain shorter periods for these children. States fear that adopting this policy will further fragment the public health coverage system, which already can be complicated for the families it serves. Costly technical systems changes may be needed to process applications and determine eligibility.

States are also concerned about the adverse consequences of a longer waiting period for children's health. Requiring children to remain uninsured for a full year prior to enrolling in public coverage, especially if there are no exceptions, increases the risk to their health and development. Research indicates that children with gaps in health coverage greater than 6 months have the highest rates of unmet needs[x], and that children with gaps in coverage are less likely to report they have a usual source of care other than an emergency room compared with children insured for a full year[xi]. Gaps in coverage may deny children the preventative and diagnostic care that could have lasting implications for their healthy development.

Considering the success to date of SCHIP in providing children with important health coverage and the potential the CMS directive has to reverse some of that success, affected states largely view this waiting period provision as poor public policy. Requiring a standard one-year waiting period will reduce the state flexibility, impose unfunded administrative burdens, and will have potential negative consequences for children's health.

3. Employer-Sponsored Insurance Coverage Erosion is Outside of States' Control

The CMS directive requires that, if states are to cover children with gross family incomes above 250 percent of the federal poverty level, they must show that employer-sponsored insurance (ESI) rates for low-income children have not declined by more than 2 percentage points. States cannot control the rate of ESI erosion.

States recognize the benefits of private insurance coverage. As discussed, most states have requirements for waiting periods following the dropping of private coverage before a child may be covered by SCHIP. Some states also see premium assistance programs as a means to encourage families to utilize employer-sponsored insurance; nine states operated premium assistance programs in SCHIP in 2005.[xii] Bipartisan SCHIP reauthorization legislation proposed to amend the rules to make it easier for states to begin to offer premium assistance for SCHIP enrollees.

Despite their interest in promoting employer-sponsored insurance (ESI), states have no control over private employers' decisions to offer insurance coverage, as employer benefit plans are regulated under federal law. States are unable to provide regulatory or oversight assistance for employees working for employers that choose to self-insure. In 2007, 55 percent of employees with ESI were covered under a self-insured plan.[xiii] And, although states can regulate private insurance companies within their jurisdictions, states cannot change the decisions of individual employers regarding premiums or cost sharing imposed on the employee, or the type of coverage offered.

The erosion in ESI has occurred for both children *and* adults, a phenomenon believed to be driven primarily by factors other than public coverage expansion. ESI rates have declined for reasons outside of a state's control. Rising health care costs and premiums have had a great impact on the ability and inclination of employers to offer coverage to their employees.[xiv] Businesses have responded to rising costs by declining to offer benefits or by requiring more employee cost sharing. This increased cost sharing has forced many families, unable to absorb the increased cost, to drop health coverage. SCHIP and Medicaid have offset the decline in ESI

coverage this decade, but there is no clear evidence that public coverage has caused the erosion.[xv]

Changes in the U.S. economy this decade also have played a role in declining ESI rates. Fewer Americans are now employed in the manufacturing sector, which historically has had high levels of ESI coverage. More Americans are working in service and construction jobs, which are less likely to offer ESI coverage. In addition, between 2000 and 2004, millions more Americans went to work in small firms or became self-employed, and these groups of workers are less likely to have ESI coverage.[xvi] States consider it arbitrary to constrain the options for program design on the basis of factors almost entirely outside of their control.

4. The Cost-Sharing Requirement is Unworkable

For children with gross family income above 250 percent of the federal poverty level, CMS directs states to adopt a cost-sharing requirement that is comparable (within one percent of the family income) to that of a competing plan sold in the state's private insurance market unless the cost requirement of the public plan is set at the federal cap of five percent of family income.[xvii] It appears through its directive, that in addition to the already established cost-sharing maximum, CMS is suggesting there also should be a *minimum* cost-sharing requirement.

Of the states that could be most affected by CMS's directive, 22 of them currently include or have proposed to include cost sharing within their SCHIP programs for children in families with incomes above 250 percent of the federal poverty level.[xviii] States establish cost-sharing provisions with caution, knowing that levels that are too high will deter eligible families from enrolling in the program and needy children from obtaining necessary services. Even if cost-sharing provisions borrowed from private health plans deter crowd-out, they may come at the cost of other critical SCHIP program goals of coverage and access.

States will not be held to the five percent of family income standard if it can prove to CMS that the state's SCHIP cost-sharing requirement is not more favorable by more than one percent of family income when compared to a competing private plan's cost sharing requirement.[xix] Most states find that comparison to be unfeasible, considering the improbability that child-only coverage is being sold currently within each state's private insurance market. If child-only plans are not on the market, states are left to look at privately sold family plans for comparison. A valid comparison of cost sharing between SCHIP coverage and private family coverage is unlikely, due to the higher cost of adult health care services, which is often balanced by higher cost-sharing requirements within private family coverage.

The Directive Usurps Congressional Authority

The CMS directive usurps Congressional authority with respect to both SCHIP and Medicaid. While the directive itself does not mention Medicaid, CMS has indicated that it intends to apply the directive to Medicaid programs.

Medicaid expansion SCHIP programs *must* follow federal Medicaid rules regarding enrollment and cost sharing. Under Medicaid law and rules, states cannot use waiting periods and they are limited to cost-sharing provisions far smaller than 5 percent of family income. The CMS directive requires states to adopt policies that contravene the Medicaid statute. In addition, because some aspects of the directive are literally impossible to achieve, it has the effect of capping SCHIP eligibility at 250 percent of the federal poverty level, which contravenes statutory language and bipartisan compromise legislation passed but vetoed.

The Directive Adds to Uncertainty which Undermines Program Goals

It is a particularly unstable time for SCHIP. Although the Medicare, Medicaid, SCHIP Extension Act has provided SCHIP with additional funding to help prevent state shortfalls in the current fiscal year, SCHIP still has not been reauthorized. While the reauthorization process has dragged on, many states have been unable to adequately plan for future coverage expansions that build on past success in covering eligible children. States, dealing with an economic slowdown, are reluctant to commit significant new state resources without a commitment of federal funding to support any coverage initiatives. Even with the uncertain future of reauthorization, some states have moved forward, which is a testament to state commitment to SCHIP and coverage for low-income children. However, many states that had planned initiatives to cover more uninsured children are putting their plans on hold without more certainty on funding.

The August 17 CMS directive is yet another challenge for states in managing their programs and threatens future coverage expansions. States that currently cover children above 250 percent of the federal poverty level face the prospect of being required to cut back their programs and turn children away who they would have covered in the past. States that have recently approved expansions above the 250 percent threshold have been stopped in their tracks from seeking CMS approval because they have not proven compliance with the CMS directive.

Conclusion

The premise of the SCHIP federal-state partnership is that state flexibility within a capped federal grant will yield exceptional progress toward a critical national goal. Indeed, ten years of experience proves this to be the case.

States are authorized under current law to extend SCHIP coverage to and beyond 250 percent of the federal poverty level. States make this choice because they know that insurance coverage is often unaffordable to families with incomes at this level. While 250 percent of FPL

is approximately median income for a family of four in Arkansas, it is barely half the median in New Jersey. In states with higher median incomes, many families need assistance obtaining health insurance despite the fact that their income would be sufficient to put them squarely in the middle class if they lived in a different state. States share the national goal of deterring crowd out, but they also know that this goal needs to be balanced against other critical program goals such as providing high quality coverage and access to health care services.

The August 17 directive imposes a single set of policies on a diverse nation. The directive is poorly crafted because it was written and issued without any input from states. The directive includes provisions that are unattainable, outside the control of states, and poorly suited for achieving the purported goal of minimizing crowd out. The directive usurps Congressional authority and impedes state actions designed to achieve the statutory goal of reducing the number of children without health insurance. The level of state concerns about the directive suggests that review and modification, in consultation with states, is warranted prior to enforcement of the directive.

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[i] While not defined in the directive, based on state conversations with CMS, the agency's reference to effective income appears to refer to gross income.

[ii] 79 percent of Medicaid-eligible children and 63 percent of SCHIP-eligible children are covered nationwide. From: Cindy Mann, Michael Odeh. *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children* (Washington, DC, Georgetown University Health Policy Institute, Center for Children and Families, December 2007).

[iii] Government Accountability Office. *Means-tested Programs: information on Program Access Can Be An Important Management Tool* (Washington, DC: Government Accountability Office, May 2005)

[iv] D.K.Remler and S.A. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, Volume 93, Number 1, 2003:67-74.

[v] CMS. Federal Register, January 11, 2001 Vol. 66, No. 8., p.2603. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=page+2639-2688.pdf

[vi] Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, September 2006), 43.

[vii] Ibid., 43.

[viii] North Carolina and Ohio have enacted legislation to increase the income eligibility for their SCHIP programs, but are currently undecided regarding their programs' waiting period.
[ix] Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Center for Budget and Policy Priorities: Washington, DC and Kaiser Commission on Medicaid and the Uninsured: Washington, DC, January 2008), 10.
[x] Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (Georgetown University Health Policy Institute: Washington, DC & The Commonwealth Fund: New York, NY, June 2006) 14-15.
[xi] Summer and Mann, 2006, 14-15
[xii] Kaye, Pernice, and Cullen, op. cit.
[xiii] Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, CA:2007). http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf
[xiv] Center on Budget and Policy Priorities, "Is Medicaid Responsible for the Erosion of Employer-Based Health Coverage?" September 22, 2006, accessed at http://www.cbpp.org/9-22-06health.htm.
[xv] Ibid
[xvi] John Holahan and Allison Cook. *Health Affairs* 27, no. 2 (2008): w135–w144 (published online 20 February 2008; 10.1377/hlthaff.27.2.w135)]
[xvii] Under SCHIP federal regulation, total cost sharing, including premiums and co-payments, may not exceed 5 percent of family income. For more information see *Charting SCHIP III*
[xviii] Kaye, Pernice, and Cullen, op. cit.
[xix] Center for Medicaid and Medicare State Operations, Health Official Letter (Baltimore, MD: U.S. Department of Health and Human Services, August 2007), SHO #07-001.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Amici Curiae Brief of the States of California, Connecticut, Massachusetts and New Mexico, and the exhibits thereto, were served upon the following individuals this 18th day of April, 2008, by U.S. mail, first class postage prepaid:

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